MICHIGAN

OFFICE OF THE AUDITOR GENERAL

AUDIT REPORT

PERFORMANCE AUDIT
OF THE

PROGRAM INVESTIGATION SECTION
PROCESSES TO IDENTIFY IMPROPER PAYMENTS

BUREAU OF MEDICAID FINANCIAL MANAGEMENT AND
ADMINISTRATIVE SERVICES
MEDICAL SERVICES ADMINISTRATION
DEPARTMENT OF COMMUNITY HEALTH

September 2008

THOMAS H. MCTAVISH, C.P.A.
AUDITOR GENERAL

391-0704-05

The auditor general shall conduct post audits of financial transactions and accounts of the state and of all branches, departments, offices, boards, commissions, agencies, authorities and institutions of the state established by this constitution or by law, and performance post audits thereof.

– Article IV, Section 53 of the Michigan Constitution

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REPORT SUMMARY

Performance Audit

Program Investigation Section Processes to Identify Improper Payments

Bureau of Medicaid Financial Management and Administrative Services

Medical Services Administration

Department of Community Health

Report Number:
391-0704-05

Released:
September 2008

In fiscal year 2005-06, the Department of Community Health (DCH) paid $7.8 billion for medical services rendered to Medicaid beneficiaries. The federal government recognized a risk that some fee-for-service and managed care Medicaid payments are fraudulent, abusive, or otherwise improper. One of the Program Investigation Section's primary functions is to conduct post-payment audits to identify potential fraud and improper payments to medical providers. In fiscal year 2005-06, the Section reported $6.9 million in identified potential improper payments.

Audit Objective:

To assess the effectiveness of the Section's efforts to identify improper payments to Medicaid providers.

Audit Conclusion:

We concluded that the Section's efforts to identify improper payments to Medicaid providers were moderately effective. We noted one material condition (Finding 1) and five reportable conditions (Findings 2 through 6).

Material Condition:

The Section needs to improve its methodology for selecting Medicaid providers to audit. An improved methodology should enhance the effectiveness and integrity of the State's Medicaid Program and increase the Section's identification of potential improper payments. (Finding 1)

Reportable Conditions:

The Section needs to improve its monitoring of Medicaid managed care health plans' efforts to identify potential improper payments, including fraud and other improper payments (Finding 2).

The Section did not sufficiently monitor the contract audits of pharmacies serving Medicaid beneficiaries (Finding 3).

The Section did not sufficiently investigate potential improper Medicaid payments identified in audits of pharmacy providers as required by federal regulations (Finding 4).

The Section should improve its continuous quality improvement processes related to identifying recoverable improper payments to Medicaid providers (Finding 5).

DCH needs to improve its efforts to prevent or mitigate conflicts of interest by entities providing services to DCH (Finding 6).

Noteworthy Accomplishments:

In June 2003, Section staff identified possible fraudulent billing practices by a pharmacy that supplied medication to long-term care facilities. The case was referred to the Department of Attorney General. Section staff assisted with the resulting Department of Attorney General investigation by providing data and analyses that helped the Department of Attorney General identify $15.9 million in improper payments and resulted in a 2006 Attorney General settlement with the provider.

Also, in May 2003, the Centers for Medicare and Medicaid Services (CMS) conducted a review of Michigan's Medicaid Program integrity policies and procedures. CMS reported that the Section had implemented a benchmark practice that CMS believed to be beneficial to other states if implemented. The Section implemented a fraud and abuse on-site review assessment tool for State Medicaid managed care health plans.

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Agency Response:

Our audit report contains 6 findings and 6 corresponding recommendations. DCH's preliminary response indicated that it agrees with all of the recommendations.

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A copy of the full report can be obtained by calling 517.334.8050 or by visiting our Web site at: http://audgen.michigan.gov

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THOMAS H. MCTAVISH, C.P.A.
AUDITOR GENERAL

September 3, 2008

Ms. Janet Olszewski, Director
Department of Community Health
Capitol View Building
Lansing, Michigan

Dear Ms. Olszewski:

This is our report on the performance audit of the Program Investigation Section Processes to Identify Improper Payments, Bureau of Medicaid Financial Management and Administrative Services, Medical Services Administration, Department of Community Health.

This report contains our report summary; description of agency; audit objective, scope, and methodology and agency responses; comment, findings, recommendations, and agency preliminary responses; and a glossary of acronyms and terms.

The agency preliminary responses were taken from the agency's responses subsequent to our audit fieldwork. The *Michigan Compiled Laws* and administrative procedures require that the audited agency develop a formal response within 60 days after release of the audit report.

We appreciate the courtesy and cooperation extended to us during this audit.

Sincerely,

Thomas H. McTavish, C.P.A.
Auditor General

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Description of Agency

The Program Investigation Section is a part of the Bureau of Medicaid Financial Management and Administrative Services within the Department of Community Health's (DCH's) Medical Services Administration. The Section's activities relating to the identification of improper payments* to Medicaid providers* include:

- Performing post-payment investigations and audits* of medical providers to identify potential improper payments*, including fraud* and other improper payments. The Section investigates complaints* about providers forwarded to it from other DCH agencies, other State departments, and the public.

- Monitoring companies that it contracted to audit hospitals and pharmacies.

- Ensuring that the Medicaid program complies with federal surveillance and utilization review requirements, which are intended to help identify medical providers and Medicaid beneficiaries* who may be improperly using Medicaid resources.

- Monitoring Medicaid managed care* health plans to ensure that the health plans have procedures for identifying potential fraudulent and abusive Medicaid costs.

In fiscal year 2005-06, DCH paid $7.8 billion for medical services rendered to Medicaid beneficiaries. DCH's total expenditures for that fiscal year were $10.1 billion. As of June 2007, the Section employed 23 of the Medicaid program's 353 full-time equated employees. In fiscal year 2005-06, the Section stated that 9 of its employees performed audits. Section expenditures were $3.5 million, of which $1.2 million was paid to contracted auditors for audits of hospitals and pharmacies.

** See glossary at end of report for definition.*

The Section reported the following efforts for fiscal year 2005-06:

Audits	
Audits of provider types (e.g., dentists, physicians, medical suppliers) completed by Section staff	11
Potential improper payments identified by Section staff	$1,000,000
Audits of hospitals completed by contractor	5
Audits of pharmacies completed by contractor	157
Potential improper payments identified by contracted hospital auditors	$4,600,000
Potential improper payments identified by contracted pharmacy auditors	$1,300,000
Complaints Received and Processed and Surveillance and Utilization Review System (SURS) Runs Completed	
Referrals or complaints received from Medicaid beneficiaries, other agencies, telephone calls, and other sources	621
SURS runs completed	327
Number of recommended payment adjustments resulting from referrals, complaints, or SURS runs	130
Dollar amount of recommended payment adjustments	$700,000
Number of audits recommended	22
Number of referrals to the Department of Attorney General	57
Number of referrals to the Department of Human Services	52
Number of referrals to the Beneficiary Monitoring Program	51
Number of times no further action was required	575
Managed Care Health Plan Site Visits/Desk Audits	
Number of site visits/desk audits (all managed care health plans were reviewed)	15
Data Extracts or Analysis	
Number requested by the Department of Attorney General - providers	120
Number requested by the Department of Attorney General - beneficiaries	287
Number requested by other State entities	732
Beneficiary Monitoring	
Average number of beneficiaries monitored	61

Medicaid is a program that pays for some, or all, medical bills for certain individuals and families with low incomes and limited resources (i.e., Medicaid beneficiaries). If, in the operation of a program, DCH identifies overpayments of program expenditures, State law allows DCH six years to recover the overpayments.

Audit Objective, Scope, and Methodology and Agency Responses

Audit Objective

The objective of our performance audit* of the Program Investigation Section Processes to Identify Improper Payments, Bureau of Medicaid Financial Management and Administrative Services, Medical Services Administration, Department of Community Health (DCH), was to assess the effectiveness* of the Section's efforts to identify improper payments to Medicaid providers.

Audit Scope

Our audit scope was to examine the program and other records of the Program Investigation Section related to its identification of potential improper payments, including fraud and other improper payments. Our audit was conducted in accordance with *Government Auditing Standards* issued by the Comptroller General of the United States and, accordingly, included such tests of the records and such other auditing procedures as we considered necessary in the circumstances. Our audit procedures, performed from February through July 2005 and from July through August 2007, included examination of Medicaid records and activities relating to the identification of improper payments to Medicaid providers primarily for the period October 2003 through June 2007.

Audit Methodology

To accomplish our audit objective, we reviewed federal regulations, State statutes, contracts, Section management reports, Medicaid and Section policies and procedures, audit reports from other states, and publications and periodicals on the topic of identification of Medicaid improper payments, including fraud and other improper payments. Also, to gain an understanding of Section activities and responsibilities, we interviewed Medicaid and Section management and staff. In addition, we used Section, DCH, and federal data and information to develop analytical tools for use during the audit.

When selecting activities or programs for audit, we use an approach based on assessment of risk and opportunity for improvement. Accordingly, we focus our audit efforts on activities or programs having the greatest probability for needing improvement

** See glossary at end of report for definition.*

as identified through a preliminary review. Our limited audit resources are used, by design, to identify where and how improvements can be made. Consequently, we prepare our performance audit reports on an exception basis. To the extent practical, we add balance to our audit reports by presenting noteworthy accomplishments for exemplary achievements identified during our audits.

Agency Responses

Our audit report contains 6 findings and 6 corresponding recommendations. DCH's preliminary response indicated that it agreed with all of the recommendations.

The agency preliminary response that follows each recommendation in our report was taken from the agency's written comments and oral discussion subsequent to our audit fieldwork. Section 18.1462 of the *Michigan Compiled Laws* and the State of Michigan Financial Management Guide (Part VII, Chapter 4, Section 100) require DCH to develop a formal response to our audit findings and recommendations within 60 days after release of the audit report.

COMMENT, FINDINGS, RECOMMENDATIONS, AND AGENCY PRELIMINARY RESPONSES

EFFORTS TO IDENTIFY IMPROPER PAYMENTS TO MEDICAID PROVIDERS

COMMENT

Background: Federal regulations require each state Medicaid agency to have methods and criteria for identifying suspected fraud cases. In Michigan, Sections 400.601 - 400.613 of the *Michigan Compiled Laws* (the Medicaid False Claim Act, Act 72, P.A. 1977, as amended) prohibit fraud in obtaining Medicaid payments.

According to Section 14 of the Department of Community Health's (DCH's) Medicaid Provider Manual, one of the Program Investigation Section's primary functions is to conduct post-payment audits to ensure that the rendered services were appropriate, necessary, billed correctly, and in compliance with Medicaid policy. The Section uses its own staff and contract auditors to conduct audits of selected providers to identify potential improper payments, including suspected fraud and other improper payments to medical providers. The State's statute of limitations law provides DCH with six years in which to recover improper payments made to providers.

The federal government recognized a risk that some fee-for-service* and managed care Medicaid payments are fraudulent, abusive, or otherwise improper. The federal Improper Payments Information Act of 2002 expanded the federal government's efforts to identify and reduce improper payments in the federal government's programs and activities. The Act was intended to improve the integrity of the federal government's payments and the efficiency of its programs and activities. The Act does not compel state agencies to comply with its provisions. However, the Act is an important indicator of the federal government's emphasis on identifying and reducing improper payments.

Audit Objective: To assess the effectiveness of the Section's efforts to identify improper payments to Medicaid providers.

Audit Conclusion: We concluded that the Section's efforts to identify improper payments to Medicaid providers were moderately effective. Our audit disclosed one material condition*. The Section needs to improve its methodology for selecting Medicaid providers to audit (Finding 1). Our audit also disclosed five reportable conditions* related to managed care health plans, contractual audits of pharmacies,

** See glossary at end of report for definition.*

questionable pharmacy Medicaid payments, continuous quality improvement, and conflicts of interest (Findings 2 through 6).

Noteworthy Accomplishments: In June 2003, Section staff identified possible fraudulent billing practices by a pharmacy that supplied medication to long-term care facilities. The case was referred to the Department of Attorney General. Section staff assisted with the resulting Department of Attorney General investigation by providing data and analyses that helped the Department of Attorney General identify $15.9 million in improper payments and resulted in a 2006 Attorney General settlement* with the provider.

Also, in May 2003, the Centers for Medicare and Medicaid Services (CMS) conducted a review of Michigan's Medicaid Program integrity policies and procedures. CMS reported that the Section had implemented a benchmark practice that CMS believed to be beneficial to other states if implemented. The Section implemented a fraud and abuse* on-site review assessment tool for State Medicaid managed care health plans.

FINDING

1. Selection of Providers to Audit

The Section needs to improve its methodology for selecting Medicaid providers to audit. An improved methodology should enhance the effectiveness and integrity of the State's Medicaid Program and increase the Section's identification of potential improper payments.

The Medicaid Provider Manual states that one of the Section's primary functions is to conduct post-payment audits of paid claims to ensure that the rendered services were appropriate, necessary, billed correctly, and in compliance with Medicaid policy. These audits can result in the identification of potential improper payments, including fraud and other improper payments, to medical providers. Also, DCH's biennial internal control evaluation for the period ended September 30, 2004 stated that the Section was to ensure accountability of all fee-for-service Medicaid providers by performing audits.

** See glossary at end of report for definition.*

The Section selects providers for audit to identify potential improper payments, including fraud and other improper payments. Our review of the Section's methods for selecting Medicaid providers for audit disclosed:

a. The Section's method of selecting providers for audit did not sufficiently consider available risk factors and, consequently, did not maximize identification of potential improper payments. By sufficiently considering available risk factors, such as the total amount of paid Medicaid claims and error rates from prior audits, the Section could maximize its identification of potential improper payments and, consequently, increase DCH's opportunity to recover Medicaid overpayments.

   For example, the Section stated that its strategy for selecting hospitals for audit was to include an equivalent number of large-, medium-, and small-sized hospitals. However, this method of selecting hospitals did not sufficiently consider the amounts of payments and the providers' past audit experiences. The selection of the medium- and small-sized hospitals for audit rather than auditing a larger number of higher-risk large hospitals reduced the Section's ability to identify potential improper payments.

   Specifically, during fiscal years 2003-04 and 2004-05, the Section's audits of hospital providers identified potential improper payment rates ranging from 1% to 54%, with an average potential improper payment rate of 16%. Potential improper Medicaid payments identified by these audits totaled $10.3 million and, historically, the providers and DCH have settled on repayments to DCH of approximately 50% of the potential improper payments identified by the Section's audits.

   If the Section had selected higher-risk hospitals for audit, it could have significantly increased its audit coverage of Medicaid payments. Medicaid payments made to hospitals that were audited by the Section totaled $63.7 million. However, Medicaid payments made to higher-risk hospitals totaled $210.1 million. If the Section had selected higher-risk hospitals for audit, it could have included additional Medicaid payments of $146.4 million, an increase of 130%. The audits may have resulted in a similar increase in the Section's identification of potential improper payments and, consequently, an increase in recoveries of Medicaid overpayments.

b. The Section rarely expanded the scope of audits of providers identified as having excessive improper payment rates.

For example, as discussed in part a. of this finding, the rates of hospitals' potential improper payments identified by the Section were as high as 54%. The hospital audits' time frames covered one year. Similarly, from May 2003 through June 2005, audits by the Section of other types of providers (such as physicians and dentists) had potential improper payment rates as high as 71% and averaged 20% over an average audit time period of 2.8 years. The audits identified potential improper payments of $4.3 million. State and federal laws and regulations allow the Section to go back as far as six years to audit paid Medicaid claims.

We recognize that conditions identified by the Section that resulted in the potential improper payments during the audit period could have been different prior to or after the Section's audit period. Such changes in conditions could have been related to changes in Medicaid Program policy or providers' circumstances. The changes in conditions could have helped improve provider billing practices, thereby reducing the potential improper payment rate, or could have helped to worsen provider billing practices, thereby increasing the potential improper payment rate.

Therefore, when the Section's initial provider audits identify potential improper payments, the Section should evaluate the risk and reward of using the six-year statute of limitations available to expand the scope of the audit to include additional years. For example, as mentioned in the noteworthy accomplishments identified in this report, the Department of Attorney General investigated and settled with one provider for potential improper payments the provider received from 1999 to 2005, a full six-year period.

c. The Section did not sufficiently consider information contained in fraud alerts from the Office of Inspector General (OIG), U.S. Department of Health and Human Services.

For example, in June 1995, the OIG issued a special fraud alert to state Medicaid agencies concerning home health care providers. The OIG noted problems with cost report fraud and billing for excessive services or services not rendered. However, from October 2002 through June 2005, the Section

started only one audit of a home health care provider, and that audit was discontinued. Using the fiscal year 2001-02 financial information used by the Section, we noted that Medicaid expenditures to home health care providers were $35.7 million. As of fiscal year 2005-06, home health care expenditures had increased to $68.1 million.

RECOMMENDATION

We recommend that the Section improve its methodology for selecting Medicaid providers to audit.

AGENCY PRELIMINARY RESPONSE

DCH agrees that there are opportunities for improving its methodology for selecting providers to audit and its process for determining when a follow-up audit is appropriate. DCH informed us that it continues to explore ways to improve its capability to identify and pursue fraud and abuse.

The Section's primary focus is on program integrity, and its goals are to educate providers on billing and to act as a deterrent for providers billing improperly. DCH believes this deterrent effect is best accomplished by auditing a variety of types and sizes of providers, not just those receiving the most money from Medicaid.

DCH disagrees that it did not sufficiently consider the total amount of paid Medicaid claims when selecting hospitals to audit, and disagrees that large hospitals are necessarily higher risk. As noted below, DCH selects its hospitals for audit so that all levels of auditable volume are considered equally, as the Section's primary function is not the maximization of recoveries. DCH informed us that it has begun considering other risk factors, such as error rates from prior audits, when selecting hospitals for audit. As DCH continues to gain experience and information from its audits, particularly of hospitals, it will evaluate its selection criteria for initial and follow-up audits, including the risk and reward of using the six-year statute of limitations, and make adjustments, as appropriate.

While DCH agrees that it rarely expanded the scope of audits of providers identified as having excessive improper payment rates, there are several reasons why audits may not have been expanded or additional audits performed. Such reasons include a major change in the process for auditing hospitals and the ability to now extrapolate findings to an entire hospital; DCH following Medicare's

guideline of auditing inpatient hospitals for a one-year period; DCH believing it is not appropriate to perform an additional audit(s) of the same provider during the time period when the provider may appeal the findings of a current DCH audit; and the commitment of resources to expand or perform additional audits limits DCH's ability to audit other providers.

DCH disagrees that it did not sufficiently consider information contained in fraud alerts from the OIG. These fraud alerts are routinely reviewed and considered in determining when audits should be performed. DCH has recently begun to document its reviews of fraud alerts.

FINDING

2. Managed Care Health Plans

The Section needs to improve its monitoring of Medicaid managed care health plans' efforts to identify potential improper payments, including fraud and other improper payments. As a result, the Section did not determine the health plans' effectiveness in identifying potential improper payments. Also, because the Section required the health plans to report only providers suspected of fraud and did not require the health plans to report the providers that the health plans identified as receiving other potential improper payments, the Section reduced its ability to identify other potential improper payments that DCH and other health plans may have made to those same providers for Medicaid fee-for-service costs.

The State contracts with managed care health plans to provide health care services to Medicaid beneficiaries. As of May 2007, approximately 64% of State Medicaid beneficiaries were enrolled in a health plan. Managed care expenditures were $2.0 billion in fiscal year 2005-06.

DCH has stated that the use of managed care for paying Medicaid costs transferred the risks of fraud and other improper payments from the State to the health plans. However, federal regulations require that the health plans implement efforts to identify fraud and abuse which, in turn, would identify other improper payments.

In October 2000, CMS (formerly the Health Care Financing Administration) issued *Guidelines for Addressing Fraud and Abuse in Medicaid Managed Care*

(Guidelines). In the *Guidelines,* CMS noted that there are new opportunities for fraud and abuse to occur as states move away from a fee-for-service to a managed care system and that the primary responsibility for the integrity of the Medicaid program lies with the state and federal governments, regardless of the service delivery system used.

The *Guidelines* also noted that states assumed that the risk for fraud and abuse in managed care was small because the states implicitly transferred the responsibility for prevention and detection to the managed care health plan using capitated payments. However, the *Guidelines* explained that experience has contradicted states' assumptions and that managed care fraud can harm a health plan's profitability and viability and can raise state costs despite capitation. The *Guidelines* also noted that managed care fraud and abuse could harm Medicaid beneficiaries who do not receive the medical services to which they are entitled.

We noted the following regarding the Section's monitoring of the health plans' efforts to identify potential improper payments to medical providers, including fraud and other improper payments:

a. Although the Section required health plans to report suspected fraud, the Section did not require health plans to report other improper payments identified and recovered from providers. As a result, the Section did not have a sufficient basis to help assess the effectiveness of the health plans' efforts to identify and recover improper payments (other than fraud) and, consequently, to decrease Medicaid costs.

   By requiring health plans to report potential improper payments (including suspected fraud), the Section could assess each health plan's effectiveness in identifying other potential improper payments. Based on these assessments, the Section could provide appropriate technical advice, proper training, and increased monitoring to the health plans that it identifies as being less effective in identifying potential improper payments. In addition, the assessments would identify Medicaid-related best practices that DCH could potentially share with all health plans.

b. The Section did not require the health plans to share the identities of providers that the health plans identified as having received improper payments with the Section or with each other. Also, the Section did not share the identities of

providers it identified as having received improper payments with the health plans. As a result, the Section and the health plans reduced their respective abilities to identify and recover improper fee-for-service payments or improper payments made to providers who serve multiple health plans.

As advised by the *Guidelines*, systematic sharing of information between the health plans and the Section would allow the health plans and the Section to more effectively identify improper payments to those providers already identified through previous audits and investigations as receiving improper payments. For example, if a specific provider was identified as receiving improper fee-for-service payments for providing unnecessary medical services, that same provider is at high risk of receiving fee-for-service payments from a health plan for performing other unnecessary medical services. However, considerations of whether to share provider information should include the significance and frequency of the improper payments made to the provider.

The Section identified 377 providers that received potential improper payments during fiscal years 2002-03 through 2005-06. However, the Section did not ensure that the identities of providers that received potential improper payments were shared with the health plans.

c. The Section's monitoring of health plans was not sufficient to assess the effectiveness of the health plans' efforts to identify and report suspected cases of fraud.

Although CMS identified the Section's fraud and abuse on-site review assessment tool as a benchmark practice, as mentioned in the noteworthy accomplishments identified in this report, the Section needs to ensure that its use of the tool will allow the Section to make accurate conclusions regarding the effectiveness of each health plan's efforts to identify fraud.

The Section's agreements with the health plans require the health plans to report all suspected fraud to the Section. Our review disclosed that, during fiscal years 2001-02 through 2003-04, the Section identified 42 cases of suspected fraud among the same types of fee-for-service providers used by health plans. During the same period, the health plans reported 9 cases of suspected fraud among managed care providers. The following table

compares the number of reported cases of suspected fraud reported for both fee-for-service providers and managed care providers during this three-year period:

	Fee-for-Service		Managed Care Health Plans	
Fiscal Year	Number of Providers	Number of Cases of Suspected Fraud Reported to the Attorney General	Number of Providers	Number of Cases of Suspected Fraud Reported to the Attorney General
2003-04	30,254	22	30,000	8
2002-03	29,530	8	22,577	1
2001-02	28,417	12	21,067	0
Total		42		9

Providers may serve both fee-for-service and managed care Medicaid beneficiaries. We used the number of suspected fraud cases identified by Section audits of fee-for-service providers during this three-year period to develop an expectation of the extent of suspected managed care provider fraud. Based on this information, we concluded that the health plans should have identified and reported more than 9 cases of suspected fraud during the same three-year period. After providing DCH with our analysis, DCH agreed that it should have expected the health plans to have reported approximately 37 cases of suspected fraud involving managed care health plan providers during a similar period.

RECOMMENDATION

We recommend that the Section improve its monitoring of Medicaid managed care health plans' efforts to identify potential improper payments, including fraud and other improper payments.

AGENCY PRELIMINARY RESPONSE

DCH agrees that it can improve its monitoring of Medicaid managed care health plans' efforts to identify fraud. DCH informed us that it uses a variety of methods to monitor these efforts, including a contract with the health plans that requires them to report cases of fraud and abuse; an annual on-site review by DCH staff with each health plan, using the health plan assessment tool developed by DCH and cited by CMS as a benchmark practice; and regular interaction with the health plans on a variety of subjects, including payments to health plan network providers.

Any suspected fraud and abuse situations are investigated, as appropriate. The Section informed us that it was recently able to hire a new staff person who will be responsible for more closely monitoring the health plans' efforts to identify and report fraud and abuse.

DCH agrees that while requiring health plans to report suspected fraud, it did not require health plans to report other improper payments identified and recovered from providers, did not require the health plans to share with the Section or with each other the identities of providers that the health plans identified as having received improper payments, and did not share with the health plans the identities of providers it identified as having received improper payments. DCH agrees with the Office of the Auditor General (OAG) that considerations of whether to share provider information should include the significance and frequency of the improper payments made by the provider, and agrees to explore the possibility of sharing information about improper payments using these criteria, as well as considering that not all fee-for-service providers participate in a health plan(s) and not all health plan providers participate in fee-for-service.

Although the October 2000 CMS *Guidelines* referenced by the OAG are not requirements, DCH acknowledges that fraud and abuse may occur in health plans and actively works with the plans to address these issues. There are several reasons why health plans may have a significantly lower rate of improper payments than fee-for-service. Some of these reasons are: unlike fee-for-service, health plans have closed provider networks, which permits them to more effectively educate providers, redirect billing practices prior to payment, and review provider utilization and potential improper payments; health plans, as managed care organizations, are in a position to have more controls over utilization and expenditures than are permitted under fee-for-service.

FINDING

3. Contractual Audits of Pharmacies

The Section did not sufficiently monitor the contract audits of pharmacies serving Medicaid beneficiaries. As a result, the Section could not ensure that the subcontracted audit company effectively identified potential improper payments to pharmacies.

DCH uses a pharmacy benefit manager (PBM) to administer pharmacy related services to Medicaid beneficiaries. During fiscal years 2003-04 through 2005-06, DCH paid $1.4 billion in pharmacy fee-for-service Medicaid expenditures through the PBM to approximately 2,400 pharmacies.

In accordance with its agreement with DCH, the PBM subcontracts with an audit company to identify potential improper payments from fraud and noncompliance by pharmacies and to improve the level of compliance within its network. The audit company used by the PBM performed three types of audits to identify potential improper payments, including fraud and other improper payments:

- Direct mail audits: A direct mail audit involves the mailing of an explanation of benefits* (EOB) letter to numerous Medicaid beneficiaries who reportedly acquired drugs from the pharmacy being audited. The EOB letters explain the benefits reported as provided by a pharmacy (e.g., prescription drugs) to the beneficiaries as of given dates. The EOB letters ask beneficiaries to complete and return forms, indicating that they received the benefit (positive responses), did not receive the benefit (negative responses), or were unsure whether they received the benefit. In fiscal year 2003-04, the audit company completed 500 direct mail audits using 27,345 EOB letters.

- Desk audits: Desk audits include the analysis of statistical information provided by the PBM to the audit company. The company analyzes the information for unusual trends and numeric relationships and then identifies pharmacies that may have submitted improper payment claims. In fiscal year 2003-04, the audit company completed 250 desk audits.

- On-site audits: On-site audits include a statistical sample of claims for selected pharmacies. The audit company reviews the claims for propriety (such as appropriate product, quantity paid, and quantity authorized). In fiscal year 2003-04, the audit company completed 25 on-site audits.

Effective monitoring efforts by the Section should include the use of measurable expectations and analyses of key output* and outcome* data, enforcement of contractual reporting requirements, and procedures to ensure that the Section documented its monitoring efforts.

** See glossary at end of report for definition.*

We noted the following regarding the Section's efforts to monitor the audit company:

a. The Section did not ensure that the direct mail audits were an effective method of identifying pharmacies that were potentially receiving improper payments.

   The audit company indicated in background information provided with its agreement with the PBM that its average response rate for direct mail audits for other clients exceeded 70%. However, the agreement between the audit company and the PBM did not specify a required response rate.

   In our analysis of the audit company's fiscal year 2003-04 direct mail audit reports, we determined that the response rate ranged from 0% to 69% and averaged approximately 30%.

   Although the Section stated, based on audit company reporting, that it was generally aware that the response rates were low, the Section did not develop measurable expectations for response rates and did not take steps to measure the response rates and ensure that the audit company developed a corrective action plan to increase response rates. Also, the Section did not ensure that the audit company used alternative audit procedures to provide the evidence needed to assess pharmacy compliance.

b. The Section did not ensure that the audit company submitted its reports within the time lines specified in its contract. As a result, the Section cannot timely ensure that the audit company performed the contract provisions as required, such as proper selection of pharmacies to audit or proper identification of questionable practices and improper payments.

   We reviewed the audit company's compliance with reporting requirements for fiscal year 2003-04. The audit company did not provide the reports on direct mail audits until 1 to 10 weeks past the due date, reports on the desk audits until 12 weeks past the due date, and reports on the on-site audits until 3 to 14 weeks past the due date.

c. The Section did not sufficiently document its monitoring efforts. Without sufficient documentation of its monitoring efforts, the Section cannot show that

its monitoring requirements were followed and that monitoring actually occurred.

For example, the Section reviewed the findings noted by the audit company; however, if a case did not result in a fraud referral, the Section did not document that it reviewed the audit. Also, the Section stated that it verified that the dollar amount of payments reported by the PBM to the Section and to the audit company matched, but it did not document that it conducted the review.

RECOMMENDATION

We recommend that the Section sufficiently monitor the contract audits of pharmacies serving Medicaid beneficiaries.

AGENCY PRELIMINARY RESPONSE

DCH agrees that it did not sufficiently monitor certain aspects of the audits of pharmacies serving Medicaid beneficiaries.

DCH agrees that it did not ensure that the direct mail audits were an effective method of identifying pharmacies that were potentially receiving improper payments. Federal regulations require each state's Medicaid program to send EOBs to all or a sample of its beneficiaries. Since direct mail audits are essentially the same as EOBs and pharmacy claims are included in Michigan's Medicaid EOB process, DCH informed us that it instructed the audit company to stop performing direct mail audits effective October 1, 2005, as this duplicated the Medicaid EOB process.

DCH agrees that it did not ensure that the audit company submitted its reports within the time lines specified in its contract, will seek to improve its monitoring of contractual reporting requirements, and will work with the audit company to ensure that that reports are submitted timely.

While DCH staff reviewed the audits and findings submitted by the audit company, DCH agrees that it did not sufficiently document its monitoring efforts and informed us that it has implemented procedures to ensure that its reviews are documented.

FINDING

4. Questionable Pharmacy Medicaid Payments

The Section did not sufficiently investigate potential improper Medicaid payments identified in audits of pharmacy providers as required by federal regulations. As a result, the Section did not review the propriety of approximately $432,000 of potential improper payments made during fiscal year 2003-04. Based on DCH's settlement rate with Medicaid providers, we estimated that the Section could have increased its recovery settlements by as much as $233,000 ($103,000 of State General Fund/general purpose funding) during this period.

Title 42, section 455.14 of the *Code of Federal Regulations* requires the Section to conduct an investigation when questionable Medicaid practices are identified. Section staff reported that they investigated 621 complaints received from beneficiaries, other agencies, telephone calls, etc., in fiscal year 2005-06.

DCH contracts with a PBM to administer pharmacy related services to Medicaid beneficiaries. The PBM uses a contract auditor to conduct audits of pharmacy providers to identify questionable practices that could result in potential improper payments, including fraud and other improper payments.

As part of 500 direct mail audits of selected pharmacy providers during fiscal year 2003-04, the contract auditor sent a total of 27,345 EOB letters to Medicaid beneficiaries, which covered more than $51 million in claims. An EOB explains the benefits reportedly provided by a pharmacy provider (e.g., prescription drugs) to the beneficiary and asks the beneficiary to complete and return a form indicating that he/she received the benefit (positive response), did not receive the benefit (negative response), or was unsure whether he/she received the benefit. We considered negative responses to EOBs to indicate potential improper payments that should have initiated investigations, as required by federal regulation.

The PBM's contract auditor was responsible for reporting required information about its direct mail audits to the Section, and the Section was responsible for any subsequent investigation. However, the Section frequently did not investigate negative EOB responses.

The PBM's contract auditor received 1,274 negative responses to the EOB letters, relating to 460 audits conducted by the PBM's contract auditor in fiscal year

2003-04. DCH used desk or on-site audits by the contract auditor to investigate 67 pharmacies having audits that reported negative responses and 5 pharmacies having audits that reported no negative responses. DCH did not investigate the remaining 388 pharmacies having audits that reported 1,070 beneficiary negative responses involving 4,195 claims and potential improper payments of $432,000.

RECOMMENDATION

We recommend that the Section sufficiently investigate potential improper Medicaid payments identified in audits of pharmacy providers as required by federal regulations.

AGENCY PRELIMINARY RESPONSE

DCH agrees that it did not sufficiently investigate potential improper Medicaid payments identified in audits of pharmacy providers but disagrees that a negative response to an EOB necessarily represented a potential improper payment.

Federal regulations require each state's Medicaid program to send EOBs to all or a sample of its beneficiaries. Since direct mail audits are essentially the same as EOBs, and pharmacy claims are included in Michigan's Medicaid EOB process, DCH instructed the audit company to stop performing direct mail audits effective October 1, 2005, as this duplicated the Medicaid EOB process.

FINDING

5. Continuous Quality Improvement (CQI)

The Section should improve its CQI processes related to identifying recoverable improper payments to Medicaid providers.

Medicaid expenditures accounted for $7.8 billion of the $10.1 billion in total DCH expenditures in fiscal year 2005-06. OAG audits and DCH audits, including audits performed by the Section, have regularly discovered improper payments to Medicaid providers. The magnitude of total Medicaid expenditures and the frequent identification of potential improper Medicaid payments by various auditors suggest that DCH and the Section need to improve their CQI process to help identify potential improper Medicaid payments.

An effective CQI process for the Section should consist of a number of components, including performance measures*. Performance measures quantify outputs, such as the number of audits conducted and potential improper payments identified. Performance measures should also quantify outcomes, such as the potential improper payments identified per audit dollar expended. Also, Section management should develop performance standards* or goals* that describe the desired level of outcomes based on management's expectations, such as a specific ratio of potential improper payments identified per audit dollar expended. In addition, the Section should have a performance measurement system to timely, completely, and accurately gather actual output and outcome data, such as a database for tracking the outputs and outcomes. Further, Section management should have a process for comparing data on actual output/outcome results with desired outputs and outcomes. Also, the Section should report its comparisons to management with proposals of program changes to improve effectiveness and efficiency. An effective CQI process can help an organization focus the allocation of its resources on management's expectations and priorities.

The Section had developed a management report that reported outputs such as the number of audits conducted, the amounts of potential improper payments it identified, and staff hours used for various tasks. However, we noted areas in which the Section could improve its CQI efforts to identify potential improper payments:

a. The Section did not sufficiently develop measurable performance goals related to its efforts to identify potential improper Medicaid payments. As a result, the Section did not identify risks that would allow it to allocate its efforts to the most cost-effective audits (see Finding 1).

   For measurable performance goals to be most useful, they need to be specific, relevant to the plan of the organization, and achievable. The Section should establish performance goals to maximize cost-effectiveness for audits conducted by the Section and on behalf of the Section.

   For example, a measurable performance goal to maximize cost-effectiveness might require that the Section audit a strategically determined number of

** See glossary at end of report for definition.*

higher-risk hospitals receiving the most Medicaid funding. Also, a measurable performance goal might require a specific number of periodic audits (e.g., annual or biennial) of each provider type to help measure the improper payment risks for each provider type.

b. The Section did not measure and compare key outputs and outcomes related to its efforts to identify improper Medicaid payments. As a result, the Section did not have the outcome and output comparison information it would have needed to provide technical support to the health plans that appeared to underreport fraud (see Finding 2).

   The Section could assess risks and improve the allocation of its limited resources by measuring and comparing potential improper payment rates and the reasons for potential improper payments identified in its audits.

   For example, the measurement and comparison of potential improper payment rates according to physician specialty or provider type may help the Section determine that some provider specialties or provider types are more cost-effective to audit than others.

   Also, a measured understanding of the reasons for potential improper payments (e.g., the percentage of missing documentation or unnecessary medical procedures) by provider type or physician specialty may help the Section to allocate its resources, suggest changes to program policy, or identify training opportunities for providers.

   According to 2003 CMS data, the improper Medicare payment rates ranged from 5.6% for ophthalmologists to 23.2% for internists. Other studies showed, as a percentage of improper payments, the reasons for improper payments. However, the Section could not provide similar measurements or comparisons relating to its audit results.

RECOMMENDATION

We recommend that the Section improve its CQI processes related to identifying recoverable improper payments to Medicaid providers.

AGENCY PRELIMINARY RESPONSE

DCH agrees that the Section could improve its CQI efforts to identify recoverable improper payments. The Section informed us that it has formal goals, although not measurable performance goals, as well as informal expectations. Also, the Section informed us that its managers regularly review reports and adjust priorities and work loads, as appropriate, and as resources allow.

DCH agrees to work toward improving its efforts to more effectively and efficiently identify recoverable improper payments, recognizing that staffing limitations and DCH management priorities may affect these efforts.

It is important to recognize that Section staff are specialized so they can determine if the services billed by providers are medically necessary. Many of the staff are licensed or certified in their respective areas of specialization. The need for specialization limits the ability of managers in reassigning staff to analyze payments made to provider types outside their area of expertise.

Section staff informed us that they regularly work with Medicaid policy staff to change policy to address issues identified by Section staff. This process results in improved efficiency for the Section.

DCH would like to note that, while the Section is involved with recovering improper payments made to providers, its primary focus is on program integrity. DCH does not view the maximization of recoveries to be a primary goal of the Section. Its goals are to educate providers on billing and to act as a deterrent for providers billing improperly. DCH believes this deterrent effect is best accomplished by auditing a variety of types and sizes of providers, not just those receiving the most money from Medicaid.

FINDING

6. Conflicts of Interest

DCH needs to improve its efforts to prevent or mitigate conflicts of interest by entities providing services to DCH. As a result, DCH could not ensure that its contractors provided their services in the best interest of DCH.

A conflict of interest occurs when a person has a duty to more than one entity that have opposing interests. A conflict of interest makes it difficult for the person to act judiciously for either entity. Whenever possible, conflicts of interest should be prevented. When conflicts of interest cannot be prevented, controls should be established to ensure that negative effects of conflicts of interest are sufficiently mitigated.

We noted:

a. DCH had not established compensating controls to mitigate a conflict of interest that occurred because a contractor that provided prior authorizations (PAs) for hospital admissions was also responsible for subsequent audits of hospital services, including hospital admissions.

   Because Medicaid inpatient hospital expenditures approximate $400 million annually, DCH needs to take appropriate steps to prevent or mitigate conflict of interest risks.

   DCH contracted with an entity to provide PAs to hospitals and providers (e.g., physicians) wishing to admit Medicaid beneficiaries as inpatient hospital patients. Providers contacted the entity whenever the providers believed that their Medicaid patient should be admitted to a hospital. DCH also paid the entity to audit inpatient hospitals' medical billings (i.e., claims) for medical necessity, including whether the Medicaid beneficiary should have been admitted as an inpatient to the hospital.

   The contracted entity had two separate units, a PA unit and a contracted hospital audit unit, that performed these tasks. Because the contracted entity's audit unit audited the decisions made by the contracted entity's PA unit, DCH needed to have controls to mitigate conflict of interest risks.

   DCH's monitoring of the contracted entity included DCH reviews of contracted entity PA decisions and audits of Medicaid beneficiaries' medical cases. DCH reviewed 480 (2%) of 21,699 PA decisions. However, DCH reviewed only 40 (1%) of 4,000 beneficiary-based hospital audits. Furthermore, those 40 reviews focused on exceptions already noted by the audit, but did not examine PA decisions that were determined by the audit unit to be without exception.

DCH's process for selecting which beneficiary-based hospital audits to review did not mitigate the conflict of interest by the entity providing services to DCH. Also, a monitoring rate of 1% and reviews of files already identified as having errors are insufficient to identify contractual noncompliance related to conflicts of interest.

b. DCH did not take steps to prevent conflicts of interest with the pharmacy auditor and did not resolve the resulting inherent conflict of interest risk.

Because fee-for-service pharmacy expenditures were $1.4 billion in fiscal years 2003-04 through 2005-06, DCH should take all appropriate steps to prevent or mitigate conflict of interest risks.

DCH contracted with a PBM to perform all tasks related to paying for prescriptions for Medicaid's fee-for-service beneficiaries. DCH allowed the PBM to subcontract the PBM's obligation to maintain an aggressive pharmacy audit and monitoring program. Although DCH and the PBM agreed that DCH would monitor the audit company, a conflict of interest between the PBM and the pharmacy audit company still existed. The PBM hired the audit company to audit pharmacies for improper Medicaid payments made by the PBM. The audit company had an interest in both auditing pharmacies and continuing its contract with the PBM.

As discussed in Finding 3, DCH did not sufficiently monitor the audit company. Also, the PBM directed the audit company to audit pharmacies and not the PBM. A part of each pharmacy's compliance with Medicaid requirements depends on whether the PBM has complied with its contract with DCH (e.g., whether the pharmacy properly billed third party insurance companies). In addition, to help DCH resolve the inherent conflict of interest, DCH should consider contracting directly with the pharmacy auditor rather than allowing the conflict of interest to exist.

RECOMMENDATION

We recommend that DCH improve its efforts to prevent and mitigate conflicts of interest by entities providing services to DCH.

AGENCY PRELIMINARY RESPONSE

DCH agrees that it needs to improve its efforts to prevent or mitigate conflicts of interest by entities providing services to DCH.

Michigan's Medicaid State Plan indicates that Michigan has selected the option to contract with a peer review organization (PRO) to perform utilization and medical review of inpatient hospital services, rather than performing these functions itself. CMS has approved this decision. DCH was aware of the need to mitigate potential conflicts of interest by the PRO and, consequently, included contract language prohibiting the same staff within the PRO from performing both of these functions. DCH acknowledges that, subsequent to the audit fieldwork, additional efforts were needed to mitigate potential conflicts of interest and, in November and December 2006, increased its review rates to 10% of PA decisions and 5% of audits. DCH will continue to review and revise the sampling sizes, as appropriate.

DCH acknowledges a potential conflict of interest exists in its PBM's contract with a pharmacy auditor, and will consider contracting directly with a pharmacy auditor in the future.

GLOSSARY

abuse	Provider practices that are inconsistent with sound fiscal, business, or medical practices and result in an unnecessary cost to the Medicaid program or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care.
audit	A post-payment review of a sample of beneficiary records maintained by a provider to ensure that services were medically necessary and billed correctly by that provider.
beneficiary	A person who is enrolled in Medicaid who can receive medical services that are paid for with Medicaid funds.
CMS	Centers for Medicare and Medicaid Services.
complaint	An allegation of fraud and/or abuse involving a Medicaid service.
CQI	continuous quality improvement.
DCH	Department of Community Health.
effectiveness	Program success in achieving mission and goals.
explanation of benefits (EOB)	A letter sent to a beneficiary that explains what medical services a provider reportedly rendered in a past medical visit. An EOB is used as a control to ensure that the medical provider actually provided the medical services.
fee-for-service	The method of paying a medical provider for each service rendered.
fraud	An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in

	some unauthorized benefit to themselves or some other person(s).
goals	The agency's intended outcomes or impacts for a program to accomplish its mission.
Guidelines	*Guidelines for Addressing Fraud and Abuse in Medicaid Managed Care*.
improper payment	Payment made for a treatment or a service that is not covered by program rules, that is not medically necessary, or that was billed but never actually provided. Improper payments can result from inadvertent errors as well as intended fraud and abuse.
managed care	The method of paying a medical provider using managed care health plans (i.e., managed care organizations [MCOs]). DCH pays managed care health plans a capitated rate per month per eligible Medicaid beneficiary. Managed care health plans, in turn, pay medical providers for contractually specified medical services provided to beneficiaries enrolled in the plans.
material condition	A reportable condition that could impair the ability of management to operate a program in an effective and efficient manner and/or could adversely affect the judgment of an interested person concerning the effectiveness and efficiency of the program.
OAG	Office of the Auditor General.
OIG	Office of Inspector General.
outcomes	The actual impacts of the program.
outputs	The products or services produced by the program.

PA	prior authorization.
PBM	pharmacy benefit manager.
performance audit	An economy and efficiency audit or a program audit that is designed to provide an independent assessment of the performance of a governmental entity, program, activity, or function to improve public accountability and to facilitate decision making by parties responsible for overseeing or initiating corrective action.
performance measures	Information of a quantitative or qualitative nature used to assess achievement of goals and/or objectives.
performance standard	A desired level of output or outcomes.
potential improper payment	Improper payment that has not yet been subjected to due process (e.g., appeal) with/by the provider that was audited.
PRO	peer review organization.
provider	A Medicaid enrolled health facility or a person licensed, certified, or registered under parts 61 to 65 or 161 to 182 of Michigan's Public Health Code, Act 368, P.A. 1978, as amended, Sections 333.1101 - 333.25211 of the *Michigan Compiled Laws*.
reportable condition	A matter that, in the auditor's judgment, represents either an opportunity for improvement or a significant deficiency in management's ability to operate a program in an effective and efficient manner.
settlement	A resolution of a case for less than the amount identified by the Program Investigation Section and noted to the provider.
SURS	Surveillance and Utilization Review System.

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